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00:00
Dr. Tino D. Piscione: So welcome to the 2021 CMPA annual meeting education session, entitled "Diagnostic Decisions — Interventions for Safer Diagnoses". Thank you for joining us today in what we hope will provide practical information and insights to help you improve the safety of your diagnostic assessments, reduce the risk of patient harm in your practice, and lower your risk of medical legal problems.

00:25
Today's session is certified as a group learning program by the College of Family Physicians of Canada, as well as an accredited group learning activity of the Royal College of Physicians and Surgeons of Canada; and you can find additional information regarding claiming credits on the CMPA website.

00:44
This session was developed for CMPA members and physicians practicing in Canada, with an understanding and appreciation of the challenges that are faced by physicians carrying out diagnostic assessments under the prevailing circumstances caused by the pandemic — with restrictions on access to care and services, and under the conditions that are required to keep both patients and providers safe. These conditions remain front of mind during this session as we navigate through some of the issues underlying diagnostic error and specifically on factors that affect diagnostic decisions, with the goal of providing you with practical advice and strategies that you can take back to your work setting to optimize safe care and to reduce medical legal risk.

01:33
At this point, I would like to state that I am a resident of Ottawa; and the CMPA acknowledges our offices located in Ottawa are on the unceded, unsurrendered territory of the Anishinaabe Algonquin nation, whose presence here reaches back to time

immemorial.

01:56
I'd also like to express my sorrow at the horrific discoveries of unmarked graves in residential schools across Canada. Please join me in a moment of silence to recognize the lives that have been lost.

02:28
The CMPA recognizes that there is inherent systemic racism in our health care structures and within Canadian society. We know that this has caused unimaginable intergenerational trauma, grief, and harm to indigenous peoples and physicians.

02:47
As an organization, we have a role to play to combat racism across health care and to support indigenous communities in their efforts to heal. We respect and affirm the inherent treaty rights of all indigenous peoples across this land. CMPA council, myself, and all CMPA staff will continue to honour Canada's commitments to self-determination and sovereignty that we have made to indigenous nations and peoples.

03:25
My name is Tino Piscione, and I am one of your co-facilitators and moderators of today's session. I'm the acting director of Safe Medical Care Learning, which is the education arm of the CMPA, and my clinical background is in pediatric nephrology — and I've been with the CMPA now for seven years.

03:47
Dr. Janet Nuth: Good afternoon, everyone. My name is Janet Nuth and I've been a physician advisor in Safe Medical Care Learning for 13 years and worked as an emergency physician at the Ottawa Hospital for over 25 years.

04:00
So now, let's find, Tino, a little bit more about who's in our audience. We're going to launch our first poll — and which of the following best describes your professional role or practice? And if you're in any of the medical specialties, including pediatrics or physical and rehabilitation medicine, you're going to choose C. And while you're voting… Tino, let's talk a little bit more about today's session.

04:27
Dr. Tino D. Piscione: (in progress) we're going to start off by setting the stage with three key messages, and then we're going to follow that up with a series of poll questions that are testing your knowledge and understanding of risk factors associated with diagnostic decision-making errors and with medical legal risk.

04:47
We'll then use three different clinical scenarios to bring to light some common issues and risk factors that are observed in CMPA case files involving diagnostic error — and

after each scenario presentation, a panel of medical legal experts will provide insight into medical legal principles, practice pitfalls, and safety strategies that are applicable to each scenario. And each time we go to our panel, we invite you to submit questions to the panel that are specific to the issues raised in the scenario presentation; and then we hope to take the last 20 or so minutes of today's session to allow for questions of a slightly more general nature, but still relating specifically to today's topic of diagnostic error and diagnostic decision-making. And then we'll wrap up by recapping our key messages, and of course, reminding you to complete today's evaluation for today's event.

05:49
Dr. Janet Nuth: Tino, we're extremely fortunate to have three very experienced panelists with us today. Dr. Louise Dion is a senior physician advisor with medical legal services, and joined the CMPA in 1998 and previously worked as a trauma surgeon and intensivist in Miami and Montreal.

06:07
Dr. Shirley Lee is a physician advisor at Safe Medical Care Learning and practiced as an academic emergency physician in downtown Toronto and continues to practice emergency medicine at the Ottawa Hospital.

06:20
And last but certainly not least, Ms. Donna MacKenzie is part of CMPA's general council and a partner at Gowling WLG in Ottawa, and she has worked with CMPA for over 25 years.

06:33
Here's our obligatory conflict of interest disclosures. All physician presenters are paid employees of the CMPA, and Ms. MacKenzie is an employee of Gowling WLG, and Dr. Piscione is also a member of the scientific planning committee for Saegis — you've heard about this already — a subsidiary of the CMPA. And otherwise, none of the faculty have any financial or professional affiliations that could be perceived as a conflict of interest; and this slide attests to the steps that were taken by the scientific planning committee to mitigate any bias resulting from affiliations disclosed on the previous slide.

07:13
We're going to be, as Tino mentioned, presenting some case vignettes in this presentation that are really for educational purposes only and are based on actual CMPA files, but they have been de-identified and altered to protect the privacy, and we ask that you please do not photograph, record or disseminate these cases.

07:32
Dr. Tino D. Piscione: Our learning objectives for today are here on this slide. So we're going to start off by listing some specific practices that reflect reasonable diagnostic decision-making. We'll also describe practical strategies that support safer diagnostic assessments, and we'll talk about the importance of enhancing team

communication in promoting safer diagnostic decisions.

07:57
So let's get on to our key messages for today. So the first key message relates to information gaps. And that is: am I missing something? We own — we know that incomplete assessments are by far the most common contributing factor in diagnostic error — not ensuring that you have the pieces to put a puzzle together. This is an issue that's magnified in certain contexts, for example, virtual care, and it relates to information gaps — what pieces of the puzzle might be missing or what just doesn't seem to fit.

08:30
Acknowledging the potential for information gaps during your assessment is a good place to start. Ask yourself: do I have all the information I need to make a reasonable diagnosis?

08:43
Dr. Janet Nuth: Here's the second key message: it's not about being perfect. When it comes to diagnosis, we don't always get it right, and in fact, the courts and the colleges understand this. They do not expect us to be perfect. The expectation is to exercise reasonable skill and judgment when it comes to diagnostic decisions, and of course, let your documentation of the clinical encounter? — like your assessments, your rationale for your differential diagnosis and your treatment plan — reflect how your decision-making was reasonable under the circumstances.

09:18
Dr. Tino D. Piscione: And our third key message relates diagnostic decision-making to effective teamwork and team communication, and that is: leverage team communication. Leverage communication with other providers to ensure that everyone is on the same page and to raise team situational awareness. I mean, let's face it. We often don't realize that we're in trouble until it's too late, and that's where situational awareness comes to play in preventing harm and decision-making errors.

09:50
Priming ourselves by identifying those high-risk scenarios and situations in our practice where decision-making errors can potentially result in serious harm can actually help to improve safety and reduce medical legal risk.

10:08
Alright, Janet. So we know from last measure we had almost close to 500 participants online with us today, and about 41% of them are family physicians. We've got — 10% of them are surgeons, and we've got — 20 to 25% are medical specialists.

10:30
And when Janet and I speak to physician groups across the country around diagnostic — about diagno — the topic of diagnostic error, we appreciate that most physicians say

they're fairly confident in their abilities to make diagnostic decisions. I mean, we spend a lot of time in training and in our ongoing professional development honing our diagnostic craft. And of course, in many practice settings, being an astute diagnostician is believed to be the mark of an excellent physician. And yet, we're not always accurate in our diagnostic assessments, for a variety of different reasons.

11:08
According to a landmark publication from the US National Academy of Medicine — and that publication is entitled "Improving Diagnosis in Health Care" — it's likely that most people will experience at least one diagnostic error in their lifetime, sometimes with serious consequences.

11:30
Alright, so here's our next poll question. It's a true-and-false question: "According to the National Academy of Medicine, the estimated incidence of diagnostic error in clinical medicine is 5%". So if you believe this statement is true, that the incident is somewhere around 5%, then select "true". If you think that it's a lot more than 5% or it's significantly less than 5%, then select "false".

11:58
And while we ate — wait for you to answer that poll question… Janet, I think it's worth pointing out to our audience today that the true incidence of diagnostic error in clinical medicine is — is probably unknown. Establishing the true incidence of diagnostic error is rendered difficult by the challenges of gathering accurate data, by the wide variety of clinical settings in which diagnostic errors occur, and of course, by the complexity of the diagnostic process itself.

12:31
Okay, so hopefully you've got a chance (sic) to answer that poll question, so let's look at the answer. The answer to this question is actually false. Based on research data, the incidence is more in the range of about 15%, and that comes from studies from autopsy reports and retrospective chart reviews, critical incident reports — which estimate that when it comes to making an accurate and timely diagnosis, we're wrong about 15% of the time. So that's about one in seven clinical diagnostic encounters.

13:08
And we recognize that for some of you, that might be an underestimate or perhaps it's even an over-estimate of your experience with diagnostic error, and that's going to depend on your practice setting.

13:21
Dr. Janet Nuth: And Tino, when we look at all our CMPA cases over the last five years — and this includes legal actions, college and hospital complaints from all types of practice — 21%, or almost a quarter, are associated with wrong, missed or delay in diagnosis.

13:40
Dr. Tino D. Piscione: So that's a fair proportion, Janet. So Janet, here's our next poll question. It's another true/false question. So, "True/false: most diagnostic errors in CMPA medical legal case files are associated with rare health conditions". True or false?

14:01
Dr. Janet Nuth: Okay, Tino, I have to ask: why is there a picture of two blue fish on this slide?

14:08
Dr. Tino D. Piscione: Well, Janet, of course, these are not Dory's parents. This of course is an image of the Devil's Hole pupfish, which is described as the world's rarest fish, found only in Death Valley National Park, Nevada. So there's — that's rare for you.

14:25
Dr. Janet Nuth: Tino, I'm sure everyone appreciates that little piece of trivia on a Monday afternoon. So let's close the polling — the voting right now. And the answer to our poll question is "false", and many of you got that answer right. It isn't the rare cases reported in the New England Journal. Most often, what we see is the common conditions, particularly cancers, especially breast and GI. We see injuries such as missed fractures, infections — and these would include pneumonia, sepsis, peritonitis — and cardiovascular conditions, including ischemic heart disease and stroke. And these are the most common clinical conditions that we see in our diagnostic reasoning cases.

15:09
And of course, the clinical conditions involved depend on your specialty. You can think about that yourself. So, for anesthesia cases, it often involves cases diagnosing a potentially difficult airway, or for the psychiatrist in the audience, it's often the risk of suicidality or increasing psychosis, and for surgical specialties, our cases often involve diagnosing post-operative complications.

15:35
Tino, let's launch our final poll question. "True or false? Most diagnostic errors result from a physician's lack of factual or procedural knowledge about a patient's health condition".

15:51
Dr. Tino D. Piscione: (in progress) of decision-making errors in the diagnostic process. And in terms of cognitive sources of error, three major categories are identified: gathering information from various sources — so that's history, that's physical, diagnostic testing; synthesizing information — so that's pulling it all together using illness scripts, pattern recognition; and then fundamental knowledge deficit — so that is the textbook knowledge procedural skills.

16:21
Alright. So hopefully, you got the chance to answer our poll question. So the answer to our poll question is “false”. In the work of others, including Mark Graber, who is an international leader in patient safety and is founder of the Society to Improve Diagnosis in Medicine — they have suggested that knowledge deficits actually account for only a small percentage of diagnostic errors, whereas the majority of diagnostic errors are attributed to faulty information gathering and information synthesis.

16:58
And in fact, when we take a look at our CMPA medical legal case file data, contributing factor analysis tells us that the majo — that the major issues in case files involving diagnostic error are in the information gathering and information synthesis phases of care.

17:17
Dr. Janet Nuth: And Tino, that’s why we often, as physician advisors, say in our presentations to members that it’s not that the physician involved in the medical legal matter didn’t know how to put the diagnostic puzzle together. It’s that they weren’t looking at all the pieces.

17:35
In fact, inadequate clinical assessment, as Tino mentioned, is very common in our diagnostic error cases that we deal with. In fact, deficiencies in the clinical assessment was identified by our peer experts in 87% of our CMPA files involving a diagnostic issue. And this includes the pertinent pauses and negatives on your history or past his — history, including information that might be available on the old records or allied health notes, as well as the details of the physical exam that could have assisted the physician in considering a broader differential diagnosis, ordering further investigations, or potentially a consult.

18:19
Dr. Tino D. Piscione: So what are some ways, then, to reduce diagnostic reasoning or decision-making errors, improve the safety of care, and potentially reduce medical legal risk, particularly in those situations when maybe a physician’s judgment is being called into question as the cause of a missed or wrong or delayed diagnosis?

18:39
Well, over the next hour, we’re going to address these questions through discussion around clinical scenarios that are frequently encountered in CMPA case files involving diagnostic error. So let’s go to our first case scenario, Janet.

18:58
Dr. Janet Nuth: Okay. This involved a 68-year-old gentleman who was assessed by a physician using virtual care, and this physician was covering after hours for the patient’s usual physician who worked in a different clinic, but as part of the same on-call group.

19:13
The patient described a three-day history of right calf pain that was worse climbing down the stairs, and he did say that he had gone on a long hike a week earlier and maybe he had twisted his leg during the hike.

19:26
The physician assessed the patient's leg over the video platform and observed that the patient seemed to have full range of motion in his right knee and ankle, and the patient pointed to maximal tenderness in his right calf, and the physician didn't see any bruising there. The patient was able to walk with a limp, but reported pain in his right calf when asked to stand on his toes.

19:50
So the physician concluded that the diagnosis was musculoskeletal right calf strain, and advised the patient to have conservative treatment, including over-the-counter analgesia, for the discomfort; and he documented that the patient was advised to follow up as needed.

20:07
Very unfortunately, 48 hours later, the patient was found unresponsive by his wife at home, and he was brought to the hospital, but he was unable to be resuscitated. And unfortunately, the autopsy did show that he died of a massive pulmonary embolism from a right leg deep vein thrombosis.

20:29
Dr. Tino D. Piscione: (in progress) Thank you for sharing that scenario. Unfortunately, it's representative of many types of case files that we see at the CMPA. But we now would like to turn to our medical legal panel for their opinions and insights on some of the issues that were raised in that scenario, and then to hear maybe their thoughts on practical advice that would help to support diagnostic reasoning and reduce harm, and potentially reduce medical legal risk.

20:57
So once again, we're joined by Dr. Louise Dion, senior physician advisor and medical legal services; Dr. Shirley Lee, physician advisor in Safe Medical Care Learning; and Ms. Donna MacKenzie, CMPA general council and partner at Gowling WLG Ottawa.

21:16
And at this point in the session, we invite you to submit your questions to the panel. To submit a question, please click on the "ask a question" button, which is located in the bottom left-hand corner of your screen. The box — dialog box will pop up. So you type your question in the box, and then press the "submit" button.

21:38
Please note that the panelists can only take questions of a general nature. They cannot

reply to questions regarding a specific matter or a specific patient, or relating to an open medical legal case file.

21:53
And bearing in mind that we have over — close to 500 people in attendance at today's event, we will do our best to make sure that as many questions as possible are addressed by the panel.

22:05
So let's start off with our first question for the panel. I'm going to pose this question to Ms. MacKenzie — Donna. In a situation such as this, were a legal action to arise from an allegation of a misdiagnosis, how would the courts determine whether the physician met the standard of care?

22:30
Donna M. MacKenzie: Thanks, Tino. If a civil action was commenced and if the matter went to a trial, then the standard of care would be looking at what this physician did — if it met an accepted standard with respect to the care of this patient. So it would be very specific to the facts and circumstances of this case or the given case as it were.

22:56
How is a judge going to determine a standard of practice in medicine when they haven't been medically trained? Well, they're going to gather lots of information, and then the — do their assessment and their decision-making. What information? In this case, the patient is deceased. The widow will say what she recalls. Our family physician will outline in great detail what she did, and reference her medical record in doing so. And then, the court will call experts to educate the court about the medicine.

23:28
What is an expert? It's really just one of your peers — in this case, family physicians with the same medical credentials as our doctor in the scenario and approximately the same kind of practice. And those experts will say, you know, in their opinions, what information you would want to gather as the family physician, what assessments or tests you would want to do, what your thinking process would be and what you would say to your patient in the circumstances.

24:02
The judge is going to take all of that information in and the judge probably wants to know something about what your medical societies, your college regulatory bodies say, and in this scenario of virtual care, I expect a judge would want to know what the college says — your college — about best practices for virtual care.

24:23
And with all of that information, they would determine if they think that this physician's care was reasonable in the circumstances that this physician and this patient found themselves in. And, as Janet said, the good news is it's not a standard of perfection. It's

what is reasonable in the circumstances.

24:45
Dr. Tino D. Piscione: Yeah. That's — the emphasis there on "reasonable". Yeah.

24:47
Donna M. MacKenzie: Exactly, Tino. And — and I compare it to a math test and — just bear with me, I'll be very quick. You don't necessarily have to get the answer right if you showed the math test marker what your thinking was, what you considered, what you — what path you went down. You can still get marks for that answer, and similarly, with the standard of care. So you're going to hear me say it again and again: please document in your medical chart. Show me — show the judge what you thought about in your assessment of this patient.

25:22
Dr. Tino D. Piscione: Thank you very much for that response. Now, here's another question. I'm going to pose this one to Dr. Lee. Dr. Lee, we heard that deficient assessment features prominently in case files involving diagnostic decision-making errors.

25:35
What aspects of clinical assessment do you think our members need to know most about that are most often found deficient by peer experts in these types of case files?

25:48
Dr. Shirley Lee: That's a great question, Tino. Thanks so much for that. You know, it's a little bit about doing the right things and doing the basics. So commonly in CMPA files what happens is that we have a lack of — an inadequate history, meaning that maybe people don't document the pertinent pauses and negatives or the past history or the family history that may actually allude to a risk factor that patient may have for a more serious diagnosis. And it's important to make sure that you do look at a cumulative patient profile. We know patients forget to tell you important information. They don't intentionally omit things. So it is important to look at that.

26:26
Another thing that was brought up earlier by Janet is the fact that there are issues with superficial physical examinations, and we see this in the CMPA cases. For example, documenting neuro exam normal (sic) when the patient presents with symptoms compatible with possibly a TIA. It's — it's kind of hard to defend. Even if you did do the examination, if you don't document or you just do check marks… Again, it's hard to know from a court's perspective, you know, whether you actually did the examination. So make sure to include pertinent aspects of a physical examination that do rule out serious diagnosis — that you were looking for them.

27:01
Two other things I want to mention — again, because the data is there if you're looking

for it as a clinician… Make sure that you look at the allied health professional notes. So always look at the triage notes, you know, the nursing notes, notes from your other colleagues, perhaps, that have consulted on the case, because they actually may provide very different information or additional information that makes you much more concerned about a more serious diagnosis. Especially patients who have been waiting a long time to be seen — they may forget, actually, that they had a different diagnosis.

27:32
And the last I'm going to mention — it's going to get mentioned a lot, probably, during this talk that we're doing — is the lack of documentation. It's so important to ensure that we do document properly when we re-assess our patients, because that is actually an opportunity when things are not going the way we usually plan when we manage a patient that we actually take another look at them, document whether or not that there is probably an involving complication, or perhaps you need to re-examine your initial diagnosis, that it may be wrong.

28:01
Dr. Tino D. Piscione: Great. Thank you. Thanks, Shirley, for that. I'm going to pose this next question to Dr. Dion. Our members are often looking for practical tips and practical advice. So this — this one relates to practical tips.

28:16
What are the — some examples that — of actions or things that a physician can take or do that can help them to demonstrate their clinical reasoning when conducting a diagnostic assessment?

28:31
Dr. Louise Dion: Thank you, Tino. So you've already heard the "D word" — the document and documentation — at least, three or four times so far, and for anybody who has contacted the association or gone through our website, you hear us say document, document and document.

28:48
Don't document at any cost. Document the pertinent information. It's not the length of the documentation, it is the content of the documentation that is important.

28:59
So for example, you would want to doc — ask and document the pertinent positives and negatives of your history and physical examination. That would ensure that you have documented the reasonableness of your decision-making and of the information that was available at the time of your assessment.

29:21
You want to make sure that you look at the medical records and at the available information in the medical record. So other consultant notes, allied health professional notes, past medical history, medication the patient is taking, ins and outs, vital signs…

All important things.

29:42
You want to consider a differential diagnosis — when a patient comes in with signs and symptoms of symptoms of something, it can be that something, but it could be something else and something else and something else. Document your thought process. Document why you're going one way or the other, but have a differential diagnosis if at all possible and pertinent at that time.

30:06
And then, pause and think. Have you asked of your patient all the questions that you think you should ask of that patient? And you may even want to ask the patient: is there anything that I did not ask you that you think is pertinent for me to know? That would be pearls of wisdom.

30:27
Dr. Tino D. Piscione: Great. Thanks for sharing that, Louise.

30:29
Dr. Louise Dion: One more thing — about validated clinical decision-making tools.

30:33
Dr. Tino D. Piscione: Sure.

30:34
Dr. Louise Dion: They are used commonly in your practice — for example, the use of CT scan in minor head trauma. If you're going to use one of those clinical decision tools or guidelines, document which one you used in the medical record, and if you're going to choose to deviate from the guideline or the tool, explain to the patient why you're doing it and document again in your medical record why in this particular circumstance you chose not to follow the guideline.

31:05
Dr. Tino D. Piscione: Great. Thank you. A lot of — a lot of great practical tips there. Thank you very much, Louise. And certainly, we are — we're seeing a lot of members raising questions about risk factors in this case. And so, taking note and documenting those pertinent positives and pertinent negatives will provide demonstration, I suppose, that the — that you had considered these risk factors that were evident. That's that information that's there — that you considered it and you would then document your reasoning for why you would weight it in a certain way, I suppose.

31:43
Great. Alright. In the time that's remaining — a little bit of time left here. I mean, I want to highlight the fact that this case here was a diagnostic assessment that was performed

virtually, and we recognize that a lot of our members are now providing care through that means. And so I'd like to pose this question to Dr. Lee. Dr. Lee, when a physician is performing a diagnostic assessment virtually — any special considerations that we might want our physician members to be aware of that might help them demonstrate, when they're performing a virtual assessment, that their decision-making was reasonable under those circumstances?

32:32
Dr. Shirley Lee: Absolutely, Tino. Thank you so much for that question. We have been giving lots of presentations on virtual care for — since the pandemic started, and this is a really common one asked by a lot of our members.

32:44
A couple things that are really important is that patients don't perceive that their virtual encounter is any different than a face-to-face. So it is important and prudent for physicians to actually discuss some of the limitations of virtual care, you know, with the fact that perhaps they may be advised to seek in-person care if after you see them during your virtual care assessment, you deem this needs an in-person examination. You need to be up front with patients about that, because they're like, well, why can't you just, you know, do what you have to and send me a medication, and I'll see you in two weeks.

33:18
Be aware of national guidelines. We have a great number of national guidelines. The CMA virtual care playbook, which was backed also by the Royal College and CFPC, is an excellent guideline to help you understand what conditions can be seen safely by virtual care and what conditions you might want to consider actually having in person. (sic) It's sort of like triaging the appropriate patient to best be seen virtually.

33:43
It's also super important to document how you formulate your diagnostic impression in virtual care. So particularly with regards to a limited physical exam — you can't do your abdominal examination virtually. So let's say, for, in this instance, in this case, with the gentleman with the leg, it would be prudent to actually document that you had visualized the full range of motion of this leg, where you had the patient move their camera, look at their leg, have them, you know, replicate perhaps some of the examination. And certainly — Donna, wouldn't you agree that that's a helpful thing, that the courts and judges look at when they see a virtual assessment?

34:20
Donna M. MacKenzie: Yeah, and, you know, I can appreciate that you're thinking to yourself, okay, the time it's going to take for my patient — who may or may not be skilled with their laptop — to actually get it set up… But imagine how reassuring it is to a judge, who is thinking: was this a prudent, careful physician? What did they do to accommodate and account for the limitations of a virtual exam?

34:50
All you have to say in your chart note is, instead of “full range of motion” — “visualized full range of motion”. That confirms to the judge that you didn’t just say to the patient, “So, can you turn your leg around?” — that you actually did the next best thing to an in-person assessment, which is see it for yourself.

35:13
Dr. Shirley Lee: Thank you for that, Donna. I just want to bring up two more quick points. I know we’re under some time constraints, but just some things to think about when you’re delivering virtual care to all our colleagues.

35:23
Be really mindful if you’re using EMR templates, which a lot of us do to maximize our efficiency, especially if they’re pre-populated. Make sure that those templates are modified appropriately, because they actually maybe your (sic) in-person templates, and it’s going to be hard to defend to say you did a complete examination if you know this was done virtually, especially with the abdominal examination.

35:46
The — lastly, the point I want to make — that safe discharge is probably even more important with virtual care. Because, you know, this is a limited assessment that you’re doing — you’re advising the patient with regards to their care — you need to make sure that you clearly explain the red flags to them with regards to the signs and symptoms that you would want them to call back to get assessed again, or seek care of the emerg department.

36:08
Also, the timeliness and the urgency — because patients may not think that a fever over three days is a big deal, but for us it’s a big deal. So again, how quickly do they need to seek care, and where would they seek that care, particularly when it’s the weekends and after-hours.

36:24
Outpatient tests, consultations, we all know things can fall through the cracks, particularly during the pandemic. That has just proven that even more. Make sure that you get a chance to verify understanding from your patients. Have them read back to you what they understand with regards to the next steps.

36:39
And if the patient refuses to be seen in person, document that. If you make a recommendation virtually that, look, you need to be seen in person, and they refuse, you need to document that with regards to the risks and benefits.

36:52
Dr. Tino D. Piscione: Great. Shirley, thank you very much for those tips. We’re going to move on. I’m just going to recap now, Janet. Maybe we’ll just quickly go over

some points here.

37:01
So we've got five points here on the slide that we really just want to highlight here. So, firstly, look for information gaps. So that means considering what additional information would help confirm your working diagnosis and rule out other more serious or potentially life-threatening diagnoses.

37:24
Secondly, consider what else could this be by formulating a reasonable differential diagnosis. Show that you thought about some other conditions, some other potentially life-threatening or other possibilities. (sic)

37:40
Show that you consider pertinent positives and negatives during your assessment by making that part of your clinical record of the encounter, and you know, acknowledge the fact that the very act of documenting those findings can actually help you think through your assessment with that cognitive process.

38:02
And use your documentation to show your thought process, especially if you're excluding a more serious diagnosis. It also helps to support continuity of care, helps others understand what was going on when you saw the patient, in particular if they come along afterwards and now the patient's condition is different from the time when you saw them before.

38:25
And plan for contingencies, what needs to be done if things change, what to look for. And as Dr. Lee had mentioned, the discharge instructions — very important, very important part of the chart — and they need to be time- and action-specific: when and where to go to if things change or if they get worse, and they need to be in the chart.

38:49
Alright, we're going to move now on to our second scenario, which involves what might be called red flag situations that are frequently encountered among CMPA case files involving diagnostic delays or missed or wrong diagnoses.

39:05
These are situations where the diagnostic error is thought that it could have been averted had circumstances within the situation or within the scenario been recognized as signaling that there is more to it than what the eye or the ear perceived. And in these instances, peer experts have commented that the physician or the care provider lost situational awareness.

39:34
So situational awareness has been described as a cognitive process of assessing a

situation in order to get a deeper knowledge and understanding of events and circumstances; but essentially, it's characterized by knowing what's going on around you, being able to detect and integrate and interpret information that's gathered from the environment and then understanding the significance of that information and integrating awareness into what you're doing in the moment. And then, thinking ahead, anticipating what might happen in the near future if circumstances don't change.

40:12
Loss of situational awareness is identified as an issue in close to half of CMPA case files involving diagnosis.

40:22
Janet, let's look at a scenario that illustrates what we're talking about here.

40:27
Dr. Janet Nuth: Thanks, Tino, and this is a little more complicated a case. So this involved a 40-year-old woman who presented to the emergency department with severe upper back pain that had been worsening over a week.

40:39
She had been reporting that she had a fall two weeks earlier and following this fall, she went to a clinic where she had some x-rays — which were reported to be normal — and prescribe some analgesia for the pain. And she's now describing this pain as being much worse and then she needs further analgesia to cope with the pain.

41:00
At triage, her vitals are normal, except the nurse noted that her temperature was 38.4. Reviewing her past medical records revealed that she had several previous visits to the emergency department, where she was diagnosed with mechanical back pain and — and treated with parenteral analgesics. She's also had a couple of visits for complicated — cations (sic) associated with IV drug use.

41:26
On review of systems, (sic) she reported some urinary symptoms — a bit of urgency — but denied any other urinary symptoms like dysuria or hematuria, and on exam, the attending physician noted some mild suprapubic tenderness and some right-sided CVA tenderness.

41:43
They dipped her urine, which was positive for some leuks and nitrates, and sent off a urine culture to the lab; and after receiving two doses of parenteral analgesia, the patient was discharged home with the diagnosis of probable pyelonephritis and given a prescription for oral antibiotics.

42:03
Twenty-four hours later, the patient, again, returns to the emergency, stating now she's

feeling weak, she's got fever, she's got chills, and the back pain is much worse. It's now 10 out of 10. Her temperature was recorded as being 39.2, and a preliminary exam illustrated that she still had this right-sided CVA tenderness.

42:23
They did blood work, which was significantly positive for an elevated white count of 21, and the rest of all her tests were seemingly normal.

42:33
So she's now admitted to hospital with the diagnosis of pyelonephritis and prescribed IV antibiotics while awaiting the results of her blood and urine cultures. Nurses' notes noted (sic) that the patient was having difficulty walking to the bathroom without assistance.

42:51
Unfortunately, the next day, the nurse reports that the patient is now having difficulty voiding and noted to have bilateral leg weakness. The team is called. An urgent MRI is performed and it confirms the presence of a thoracic spinal epidural abscess, and very unfortunately, despite the surgical intervention, the patient is left with paraplegia.

43:18
Dr. Tino D. Piscione: So thanks, Janet, for presenting that scenario, and although the ultimate diagnosis in this scenario was a rare one — spinal epidural abscess — the red flag in this scenario was that of a patient presenting on more than one occasion with an unresolved or evolving symptomatology or — or physical complaint. And this is an example of a situation that is often observed in our case files of diagnostic errors, and peer experts have commented that it might represent a missed opportunity to rethink the diagnosis.

43:57
So let's turn to our panel now for their thoughts on that scenario and how physicians might raise their awareness to red flag situations or circumstances; and again, we invite you the audience to submit questions to the panel concerning the scenario that was just described which highlights red flag situations and loss of situational awareness.

44:20
So I'm going to pose this first question to Dr. Dion. Louise, the — the scenario that we just described illustrates repeated presentations with unresolved symptoms as an example of a frequently observed situation where it's felt that the physician named in a lawsuit or complaint may have lost situational awareness. What are some other examples of situations featured in CMPA case files where loss of situational awareness is believed by experts to have contributed to the diagnostic error or to the delay?

45:07
Dr. Louise Dion: I want to start by repeating something you said during the introduction part of this presentation, which is: these — the loss of situational

awareness accounts for about 50 — or is a factor in about 50% of our misdiagnosis or delayed — so it's very, very common. Knowledge gap is extremely rare. So I think those are two very important points.

45:34
There are three different themes that we find in our CMPA files regarding delayed diagnosis or misdiagnosis. One is the repeated visit to the emergency room for the same symptoms. We also have missed abnormal vitals. So really important to go look at a triage sheet if you are an emergency room physician, or look at the nurses' notes, if you're working outside the emergency room setting. There are pearls in there where you see the abnormal vitals and you need to figure out why the vitals are abnormal. You can't just discard that.

46:12
You can have an atypical evolution to a common condition — another thing that we're seeing. And then you can have failure to improve or to respond with first-line treatment. All the different things that we find.

46:30
I would say that if we're facing these scenarios, again, pause. Think. Start from the beginning. Ask a colleague. But really look at these scenarios in detail.

46:48
Dr. Tino D. Piscione: Yeah, and I mean, the ones that you described… These aren't — these aren't rare birds themselves. I mean, these are things that happen to us, you know, not routinely, but they happen often, where these sort of situations arise. Thanks. Thanks very much for that.

47:06
So, let's look then to some practical ways to — to try and raise the situation awareness. And so, Dr. Lee, I'm going to go to you. Can you give us some thoughts, then, on what might be some practical strategies that physicians can — can implement to try to raise their situational awareness?

47:26
Dr. Shirley Lee: Well, I have to admit when I was hearing what Louise was saying, I've made all those mistakes, right? You learn from years of practice. I'm in my 26th year of emergency medicine practice, and if I had a dollar for every time I had a repeat presentation where I always (inaudible) that rule down, it's another opportunity to revisit what's going on with the patient. Is there something else going on?

47:48
Those abnormal files really bother me. When I get a handover and I see that someone's tachycardic or hypotensive unexplained but in the department for a long time and it hasn't resolved or improved… What else is going on?

48:01
And that failure to improve or respond to first-line treatment… I mean, I'm as probably vulnerable as the next physician. I get disappointed when patients don't actually get better with my usual treatments for migraine or whatever else. And — but however, that teaches me to slow down, to think — what else could be going on? Maybe this isn't a migraine. Maybe it's something more serious. So thank you for that, Louise. I think I've learned those the hard way and they are definitely ingrained in my practice.

48:30
But getting back to what you're talking about, Tino, with — about practical strategies for us as physicians to counteract these factors, you need to be able to recognize a high-risk situation. And what I mean by that is there are physician-related issues and patient-related issues. I'm going to probably focus more on the physician-related, because the — easier to change or to be aware of is probably within yourself. (sic) And what I mean by that is knowing when you're not at your best with the full acumen to do your diagnostics.

49:04
So for example, at the end of a shift, when you're rushing to get home, to pick up your kids or it's late at night, you may actually make decisions you don't usually make in your practice with regards to patient care. Things to think about with those types of situations is know when you need to slow down. As Louise alluded to, when you do that first set of treatment and it doesn't go the way you expect it, slow it down and think what else could it be.

49:30
Sometimes — and particularly hard for me, working in a busy emerg department — it's really hard to minimize interruptions and distractions. Some of the areas I work in are really noisy, and I actually selectively pick a computer or an area where I can actually do some thinking, because I know if I get interrupted — and there's good data on this — that my chance of going back and finishing the activity for a patient is probably 40% less likely. So again, minimizing interruptions, distractions when I can when I'm making important diagnostic decisions in complex patients is really important.

50:03
It's important to write it down, and this is something I teach my learners all the time. I'll say, what's your differential diagnosis? Write it down. What are the things you think it most likely is? What are the things you don't want to miss? By writing it down, that opens up your mind with regards to looking for patterns and seeing the possibility of something more serious, even if the patient doesn't look that extremely unwell.

50:27
I like asking people — instead of saying "Tell me what you think it is", asking them instead "What's your working diagnosis?" And I do that to myself as well, because when you ask yourself what your working diagnosis is, you're less likely to anchor yourself and say, I'm going to make it this diagnosis no matter what, and leaving very

dissatisfied, you know, with the fact that you may have made the wrong diagnosis in the patient.

50:50
As Louise has mentioned, ask for help from your team. You know, I can't count the number of times when I see my colleagues and myself or other specialties — where we asked nurses what they think is going on. Right? Where we asked other consultants that have looked at the patient before for some help; or you might ask another colleague when you have that opportunity. Say — can I bounce this case off of you? It's just not fitting right? What do you think? And to them, they have no cognitive load. They have a clear mind, and they are able to actually say, yeah, it's pretty obvious it could be this. And you know, it can giving you (sic) that opportunity to talk about a case.

51:25
I think one of the hardest things for us as physicians is understanding when we may have unconscious bias. We don't know what we have biases against. I'm still learning this far into practice about biases I maybe have, perhaps to certain things — when I alluded earlier about patient issues. When there's a language barrier, I know I have to pay — be more diligent. I may miss important history and physical findings. Behaviours, right? Cognitively challenged patients or patients that perhaps aren't at their best may get a rise out of you, where you might get certain emotions, and you know you're not making good diagnoses.

52:03
So also be aware of your cognitive load, and I talk a lot about this when I'm teaching learners. You know, we have to know how much we're capable of managing multiply (sic) at a time of patients, but also understand when there are ways to offload your cognitive load, like using decision guidelines and rules to help you make those decisions with regards to protocols. And really do recognize when you're at best. Have a system, you know, where you actually share it with your colleagues — sometimes I'll say "I'm not at my best tonight", you know, starting a busy late shift, and "I'm a little tired, so make sure you watch out for me and let me know if I'm doing something wrong or you see something, because I need — I need your help and we've got this together".

52:45
Dr. Tino D. Piscione: Great. Thanks, Shirley. There's a lot of great points there. We've got a number of comments being raised by our audience members about, you know, some of the red flags and the history here, that the — the history of IV drug abuse. And many of the things that you — that you mentioned, you know, in isolation — great, but pulling them all together might actually help to then suddenly say, hmm, oh that element of the history actually might actually mean more to this particular patient scenario then if I, you know, if I didn't write it down or if I didn't actually go and speak to my nurse colleague, who might say, you know, what did you think about that history? Could that be something else? So, thank you very much for — for pulling together many — many different points there.

53:32
I have a question here that I want to ask to Ms. MacKenzie. So the diagnosis in this scenario was a — was a rare condition. So from the court's point of view, does standard of care apply differently in allegations of negligence that relate to a diagnostic error when the diagnosis is rare?

54:01
Donna M. MacKenzie: (inaudible – off microphone) answer, but I'll stretch it out a bit more. No, for the purposes of the court, it doesn't matter if a physician has seen something a hundred times or it might be something that they rarely if ever see in their career. The legal test is going to be the same, and that is, as we mentioned earlier: was the physician's information gathering and diagnostic reasoning acceptable in terms of a standard of practice of what other physicians in their circumstances would have done?

54:38
And so, you know, we look at what are the circumstances here. We've got a busy ER. Our doctor, unlike the first scenario, has a lot more information to absorb. You've got the patient had visits before. (sic) You've got triage notes. You've got your own physician assessment. You've got test results. You've got to absorb all of those and compile those as you reach your diagnosis the first time.

55:04
In this scenario, I think the court would be particularly interested in the second visit. Right? The court knows that there was an error of diagnosis in the first visit. The judge is going to say: and what did they do time two?

55:18
And so, it's exactly as Louise and Shirley have been saying. It's — you're going to do the same thing that's the best thing for patient care. You're going to ask yourself, what are the circumstances here? What, if anything, is changing? And if something is changing, how does that inform my thinking?

55:39
A simple example. When I was hearing the — Janet recite the scenario… A temperature taken in the first visit and a temp taken in the second visit. In the second visit, as a physician, you can just put in your medical record "temp X". But what I'd prefer you to do, to show that you are a thoughtful and reconsidering practitioner — very simple — "temp X increased from first visit of temp Y".

56:09
It's two words. I'm not asking you to document a book as you compare and contrast what you are seeing in your patient in the second visit as opposed to the first. But just show something in the record to show the judge that you're being mindful.

56:27
You know, we talk about "in the circumstances", and remind yourself that if you get an

unexpected test result, one that doesn't align with that diagnosis from visit one… If you have your patient with meaningful, evolving changes of symptoms, then your circumstances are changing. And so, you have to, as a professional, reflect really on what your thinking is.

56:56
You know, a court, if they see evolving medical circumstances and a status quo perspective from the physician, is really less likely to say that you met the reasonable standard of care in all of the circumstances. Thanks, Tino.

57:15
Dr. Tino D. Piscione: Yeah, thank you very much, Donna. Thanks. So we're going to just sort of sum up here. So we've got a number of points on the slide. There's five of them there that sort of sum up the things that were raised in our discussion with the panel.

57:29
So the first one there mentions priming and slowing down, and I think, Dr. Lee, you — you touched on this. And so, recognizing — and Dr. Dion as well — what might be the red flag scenario in your practice and then using them as triggers to prime yourself to slow down… And we're not talking about slowing down your thinking or acting more slowly. We're talking about using those triggers to heighten your awareness, focus your attention, and be more alert to what's going around you (sic) and to activate the systems around you — conversations with colleagues, sharing of information — to help to raise that level of awareness.

58:13
The second point on the slide here is scan and search. So that means be proactive about looking for information in the environment, and that includes reading the notes of nurses or other allied health professionals who may have a different perspective or take on a patient's care. They may have heard different pieces of information and their encounters with the patient or even with the patient's family.

58:38
Check the patient's past history or pay attention to changes in the physical signs, like vitals. Use a diagnostic pause to ask yourself: does this make sense? Is it following a usual trend for this type of condition? Is there something else that might be going on?

58:58
Ask what-if questions to plan proactively for contingencies. What if the vitals change, then what's my plan? What parameters do I want to monitor? So what if the urine output starts to decrease? What if the oxygen requirements start to increase? What am I going to pay attention to? What I'm going — what am I going to ask my colleagues to monitor, to forewarn if the patient's status is changing?

59:25

And use reflective practice to learn more about yourself and your approach to diagnostic problems. Ask yourself, you know, is my thinking subject to bias? Was there anything about the situation or the scenario that was pushing my buttons, or that might trigger me to become more aware the next time that I encounter something similar to this?

59:50
Alright. We're going to move now on to our third topic today, and that's on team factors, and team factors — they figure prominently in CMPA case files involving diagnostic error. They are evident in about 53% of those case files, and deficiencies in communication are a common feature which many times experts, peer experts, believed impacted on the patient's continuity of care. And this includes things like documentation of the rationale for diagnostic investigations and treatments; communications between physicians and other health care providers; and also communication between the physician and the patient and the patient's family, because they're also a part of the team — concerning follow-up plans or discharge instructions.

1:00:49
The impact of ineffective team communication on situational awareness and on diagnostic decision-making is particularly evident during care transitions and handovers. When we took a look at our case files involving care transitions, it revealed that about 60% of those types of cases involved team miscommunication that was believed to have contributed to a delayed, missed, or incorrect diagnosis. And in many instances, the diagnostic failure was attributed to members of the patient's health care team losing situational awareness either because they failed to gather or comprehend the significance of relevant information that was available to them, or they failed to project the consequences of that information in the near future.

1:01:43
So let's consider the relationship between teamwork and team situational awareness in the following case scenario that speaks to a delay in diagnosis and treatment.

1:01:59
Dr. Janet Nuth: Tino, this next case involves a young male who was admitted to the ICU after suffering multiple injuries from a high-speed motor vehicle collision, and his injuries included a head injury, hemothorax and a stable pelvic fracture. Eventually, an orthopedic surgeon — and let's call him Ortho #1 — is consulted regarding his pelvic fracture and during the examination, he notes, "Hey, this guy has got a really swollen right elbow. I think something's going on there", and an x-ray is ordered which actually confirms a right-elbow dislocation.

1:02:34
The patient's care is handed over to the on-call orthopedic surgeon. So let's call him Ortho #2 — and he performs a closed reduction and casting under sedation in ICU. He then orders the post-reduction x-rays to confirm alignment, however, there's some delay in doing that, and by the time he finishes his on-call shift, the x-rays still aren't done.

1:02:58
So he asks the patient's nurse to call Ortho #1 to follow up on these x-rays once the study is completed, and he leaves the unit and doesn't speak to Ortho #1 or the ICU staff about the need of these pending missing x-rays.

1:03:14
So there's a shift change of the nurses. The x-rays are then completed, and the post-reduction films unfortunately show that the joint is incompletely reduced, and the message to review this film was never passed on to Ortho #1 and no one ends up reviewing them.

1:03:33
It is until three weeks later that Ortho #1 — he's re-consulted. Can the patient now mobilize? He reorders the x-rays of the elbow and realizes that the initial post-reduction films and the repeat films that are done now three weeks later showed a persistent subloca — subluxation in the joint. And the patient has ongoing pain and decreased range of motion and eventually requires quite a bit of additional reconstructive surgery.

1:04:03
Dr. Tino D. Piscione: So thanks, Janet, for sharing that scenario. So here's a scenario where a number of factors came into play. You have a critically ill patient who has a range of problems, some that are serious, some perhaps less serious, relatively speaking. Multiple providers. You have a handover situation. There's a nursing change of shift. There's a number of assumptions, and eventually, a patient who suffers harm.

1:04:35
So panel, I'm interested in knowing your thoughts about the issues that were highlighted by this scenario. And again, we invite our audience to submit questions regarding teamwork, team communication, handovers and other issues that are raised by the scenario just presented.

1:04:53
So, I'm going to start things off here with — with Dr. Lee. So Dr. Lee, earlier it was mentioned that 53% of CMPA case files involving diagnostic error involved breakdowns in teamwork and team communication. So based on your experience with these types of cases, what would you say are the most important facets of teamwork that physicians should be focusing on that would help them to reduce the risk of patient harm and reduce their medical legal risk?

1:05:31
Dr. Shirley Lee: Thanks for that, Tino. I'm going to start at a high level because I think there are some things we need to think about as we evolve in health care and we all work on teams. You can't do this alone as a physician. You need your team in order to deliver the best care for your patients.

1:05:46

Probably one of the biggest issues that comes up for physicians with regards to team issues that result in diagnostic errors or issues is the fact that we sometimes don't clarify our roles and responsibilities. It's really important when I'm dealing with multiple people on my team who are at different levels of training, have different responsibilities, that you do actually clarify who is doing what and when.

1:06:12
It's also important that when your team has those conversations, like, let's say at a handover, that you avoid those assumptions and that you actually clarify ambiguity. And that is not meant as a questioning of your authority, but it is really important to have the opportunity where my — when I pass on information to a colleague, that they can clarify, you know, points that I think I'm being clear about, but they need further clarification about — the test they need to follow up or the — the medications being given.

1:06:43
Avoiding assumptions is really critical. We already have a narrative in our head when we hear a patient's story, and it's easy to think, okay, you want me to do x, y, and z, but actually, they want you to do something different. So avoid the assumptions if you can, and listen actively to your colleagues when they're sharing that information so that you are fully taking it in and understanding what they actually want for the patient. Again, it's important to be actively listening and deliberate about this being a really important aspect of patient safety, and also with regards to how we do diagnostic issues.

1:07:18
Often what will happen in teams is that if you give the opportunity for your colleague to ask those questions to clarify their role and that you also give them an opportunity to confirm understanding — in other words, they may do closed loop communication where they feed back to you — "So my understanding is you want to do x, y, and z, and I'm going to this, x — a b, and c". It's so helpful when you actually do that closed loop communication so you can actually adapt and clarify any of those issues.

1:07:44
As well, lastly, it's of course important if you are working on a multidisciplinary team and you're handing over to a new team, make sure you document those discussions with teams, right, Donna? Because the next team will have no idea what you've done for the patient, what needs to happen next, and we have to do this in the best interest of our patients.

1:08:06
Dr. Tino D. Piscione: Thanks very much for that, Shirley. Donna, I'd like to go to you for the next question here.

1:08:14
So we — we — this is a scenario that featured a handover situation. So — so the question here is, in legal matters when a patient suffers harm and alleges that the harm

resulted from care being transferred from one physician to another, what might the courts look for as evidence that the physicians who were involved in the handover acted in a manner that was reasonable, prudent and in the patient's best interest? So I guess it's highlighting the — the medical legal principles around the handover situation.

1:08:49
Donna M. MacKenzie: Yeah, exactly, and — and really, what the court is going to look at is the individual physicians and what their actions and role were. But importantly, because the legal test is to look at the circumstances, they're going to look at what that individual physician's roles and responsibilities were within the team, you know, how they performed within the team. And of course, the more players, the more important the communication and documentation so things don't slip through the cracks, and the court is going to look for that communication and documentation.

1:09:25
Let me use the specific scenario example here of a physician who ordered a test and it wasn't available before that Ortho 2 went off-shift. Fair enough. The court can appreciate that there's a lot of tests that you order in a shift and it's not reasonable that you are going to be individually responsible.

1:09:47
But then the court is going to look at, okay, what system is in place to make sure that things don't fall through the cracks? If there was a formal system in this hospital for this ordering and informing the next ER physician, follow that system. Don't be the lone wolf going outside of the rules of your hospital.

1:10:07
If there isn't a formal system in place for the test result that you nee — know needs to be followed up, create your own little mini system, as this physician did, right? This Ortho 2 knew that the test result hadn't come back and did something to ensure that that information was going to get conveyed or — to Ortho 1. The question is, what did he do, and did that little mini system that he created… Would it be reasonable in the eyes of the court?

1:10:40
And I — I noted here this specific scenario. So Ortho (sic) asked the nurse to call Ortho 1 to follow up on the x-rays once the study is completed. So we, of course, all here have 20/20 hindsight. It's all so easy, isn't it, to see that the test didn't come in in that nurse's shift, she didn't then think to say to the next nurse coming on that they should contact Ortho 1.

1:11:08
A judge is going to say to themselves, okay, that, you know, expect the unexpected in the ER, and the ER physician knows that things don't always go tickety-boo as you might hope they would go. So what could this Ortho have done to create that safety net, right? To create that next level of "if things don't go as I expect them to, is there

something else?”

1:11:34
And the something else is what we’ve said to you again and again: documentation, right? If our Ortho had put a note in the chart that said “Nurse to follow up with test result and convey to Ortho 1”, that nurse, we know, forgot, but the next nurse who came on shift and followed — she’s a responsible nurse. She’s going to have a look at the chart of the patients that she’s responsible, and she’s — responsible for, rather, and she’s going to say to herself — hopefully — “Oh, okay. I wonder if it’s in yet. I’m just going to have a check”.

1:12:12
And so this is how you satisfy the court that you’ve been thinking ahead, that you’re watching for how things fall through the cracks, and that you’re communicating with each other to support each other as a team to support good patient care.

1:12:29
Dr. Tino D. Piscione: Thanks. Thanks for highlighting those points, Donna, because some of the comments that we’re also receiving from members are asking, you know, like, how do you sort out each individual’s contribution here, and one of the things I’m going to take away from what you said is, it’s not just about sorting out each individual’s contributions, but working together as a team. You can actually support each other and support the safety of the patient, not just by covering yourself, but also working together collectively as a team. So thank you very much for bringing that up.

1:13:04
I’m going to ask — Shirley, I’m going to ask you the next question, because handovers is a topic that we often get asked to give educational presentations on. And so, maybe you could just very briefly share with us insights on what can — what can physicians and non-physician health care providers do. What can they do to optimize their handovers? What are some practical tools and strategies?

1:13:29
Dr. Shirley Lee: Thanks for that, Tino. What I think about handover — handover is a high-risk activity for physicians and for the team, because we’re handing over the care of the patient. So you want to optimize that situation to ensure that we keep our patients safe.

1:13:45
In general, the basic rules about handover that I would say from our data files that we see in cases… It is always best, if ever possible, to do handover face to face. That’s when you have the opportunity to ask the questions, clarify ambiguities, and I know that’s not always possible in certain settings — where handover may actually be by phone, where you’re busy doctors working in different hospitals, and at least if you can do a telephone handover, that allows, again, the chance for asking questions, clarifying ambiguities and what happens next for the patient.

1:14:19
If you do a shared handover tool that's in writing, for example the EMR, make sure it's secure and there's no risk of breach of privacy. Certainly, when we get asked to do talks about handover, we often get asked about texting as a handover, and I would, you know, warn our — our members that texting is a very unsafe way to share information about a handover and particularly you have to make sure that there's no patient identifiers. It does not secure things privately.

1:14:53
Make sure you optimize the environment. Make sure the handover is a priority that you allow adequate time to do that handover, that you're not rushing off and that the receiving colleague doesn't have an opportunity to actually do a proper handover to you. It's — it's one of the things that probably is one of my personal issues with regards to ensuring that we're not rushing off at this important juncture.

1:15:15
If you use a standardized handover tool — great. There's so many of them — I-PASS, SBAR — or you may create your own as a team in what you decide is the best handover tool for yourself. And make sure that you do clarify this as a priority for your team, so that we can optimize patient care.

1:15:36
Dr. Tino D. Piscione: Great. Thank you very much, Shirley, for summarizing many of those tips.

1:15:43
One last question I'm going to ask here to Dr. Dion, which really just kind of — it's about bringing it all together here with team communication and diagnostic decision-making. What would we say physicians and their health care team members keep in mind in terms of optimizing team communication in order to support or enhance diagnostic decision-making?

1:16:08
Dr. Louise Dion: Thanks, Tino. So you said the two important words, which are "team" and "communication". You are working on a team, a multidisciplinary team of individuals who have expertise that is different from yours, that may view a problem or a patient from a different viewpoint. This is all complementary.

1:16:32
All of these individuals have a voice. It should be recognized that they all have a voice in the treatment of the patient, and we should be mindful to hear these people, and I'm leading to the concept of psychological safety. When I was introduced earlier, I was introduced as a surgeon, and as you can tell from the grey hair, it's a few decades back, and I could tell you that psychological safety was probably a foreign concept for many of — surgeons during these olden years. Fortunately, now we've all evolved and

psychological safety has been recognized as one way of ensuring patient safety.

1:17:13
Make sure that everybody in your group knows that they have a voice, that they are encouraged to speak, and that people listen to what they have to say. There are no stupid questions — so I was told back then.

1:17:28
Look for opportunities to share the same mental model. Discuss your thought process. Use briefings. Use huddles. Use scheduled huddles, use unscheduled huddles if you have a — something that happens that you are — you did not expect. Make sure during these huddles that everybody is allowed to speak and is heard, that everybody's roles and responsibility are clear, as has been discussed by Shirley and by Donna, and that there is documentation of the huddle discussion and the huddle decision.

1:18:05
We know that surgical checklists are used in operating rooms. You may want to have checklists for your huddles or your briefings the same way you do for your — your transfer of your handovers. And if you do that, it might make it that you're going to cover everything and that everybody's going to have their piece to say.

1:18:27
Dr. Tino D. Piscione: I — I appreciate so much, Louise, how you — how you answered that question, because it — in saying that it's not — it's not so much the actions that you're doing, but it's the environment that you create where those actions live, that that is really what's so important. So, thank you. Thank you so much for that.

1:18:45
Alright, so I'm just going to sort of wrap up this little — this particular scenario here by looking at what we can do to enhance team communication and promote safer diagnostic practices. So there are four points here that our panel touched on. So one of them was closing the loop on tasks and that means clarifying what needs to be done when and by whom, and verifying that those rules and responsibilities are not just acknowledged but they're understood, the scope of them is understood. I know exactly what I'm supposed to do and when.

1:19:23
We talked about structured communication tools and techniques which build on closed loop communication skills. They can help organize the exchange of critical information, but they are also, very importantly, close that loop (sic) by validating comprehension.

1:19:39
Creating environments, as Dr. Dion had mentioned there, where people feel safe to exchange information, to raise concerns, to speak up — that can help to identify new information or perspectives that perhaps wouldn't otherwise have been recognized; and leveraging existing activities in your day-to-day routine — huddles, briefings, team

meetings — to create the shared mental models to make sure that everyone is on the same page and to create those opportunities for teams to practice speaking up when perhaps the stakes are slightly lower than in those acute situations when the stakes are so much higher. So thanks very much for — for that.

1:20:24
Alright. So in the last 15 or 20 minutes or so, we've got — we're at that point in the session where now we are asking — we're inviting you to ask our panelists any questions that you have may have (sic) regarding the risk of harm or medical legal risks relating to diagnosis or diagnostic assessments or diagnostic reasoning. And again, we'll try to get as many as questions in (sic) as possible.

1:20:53
So here — I've got a question here. Donna, I'm going to pose this one to you. And so, this question I think relates to the current situation that many of our members are facing and patients are also facing at this point in the pandemic, and that is systems backlogs. So, the question here is: Could I — could a physician — be held responsible if a patient's diagnosis is delayed because of a backlog in services due to the pandemic?

1:21:30
Donna M. MacKenzie: Thanks, Tino, and certainly, you know, we as lawyers representing physicians recognize the difficult circumstances you find yourselves in and the evolving circumstances you find yourselves in.

1:21:46
You know, the standard of care doesn't change the legal test just because of a global pandemic, but the global pandemic and its impact on health care resources is one of those circumstances that the court would most assuredly take into consideration if a patient commenced an action alleging there was a delay in diagnosis.

1:22:10
So this specific question, Tino, said "a delay in diagnosis due to the pandemic". So let's take the easiest example there, and that is closure of the ORs in some hospitals for periods of time. So, you know, your general surgeons who have their patient list organized and suddenly aren't operating aren't going to be held responsible individually for the closure of the ORs. They don't have control over that. So there's some — there's reassurance there.

1:22:44
But I don't want the viewers to be overly reassured, because just because it's a global pandemic time, that can't be your reason for perhaps not organizing your patient list. You know the ORs are going to open again, and so, in that period when they're not open, you want to be doing something. You want to be communicating so that you can figure out how you're going to be good to go when the ORs are again operational in the example I'm using.

1:23:18
So, you know, have communications with your referring physicians and the patients. Have communications with your colleagues in your department. Have communications with your general surgeon friends from law school. What are they doing in their hospital? You want to be able to — for good patient care, obviously, but also in the event that a patient does make that allegation — you want to be able to show that you were doing what was reasonable in these difficult circumstances.

1:23:51
Dr. Tino D. Piscione: Great. Thank — thanks for that, Donna. You know, we have a couple of comments here from, I guess, community-based physicians who are also asking, you know, like, how do they manage these system backlogs that are really things that are out of their control. So maybe… Shirley, do you have anything to perhaps add to Donna's response in terms of, like, what can the individual physician do that can help reduce their patient's risk of harm from a delayed diagnosis and their — and the physician's risk of medical legal problems with these system backlogs that — that seem to be out — outside of any individuals control?

1:24:30
Dr. Shirley Lee: Yeah, Tino. It — you know, I have full — so much respect for our colleagues doing all the hard work during this pandemic. We've, you know, we've been slogging out day in, day out.

1:24:41
As Donna has alluded to, we cannot under-estimate the importance of communicating with our patients. Patients are extremely anxious post-pandemic with regards to getting the care or access to care that they need. I mean, I — I see them as I work in the emerg department.

1:25:01
It's really important that we communicate to them that if there are delays with regards to diagnostic issues or seeing a consultant, that we communicate that to them, and not alluding to the sense that they're getting substandard care. I think that's very important from the perspective of not denigrating that — but the point about ensuring that there is a delay in getting your ultrasound or seeing the specialist as we are catching up post-pandemic after the full closures of the ORs — we're doing our best to mitigate that situation for you.

1:25:34
What's important with the aspect of patient communication, though, is that if you've got a patient on the list that you're concerned about, that you're trying to work up… For example, I think of the family physicians who are, you know, waiting to get their patients in to see a certain specialist to investigate for potential cancers — that you have that conversation with your patients about what they need to watch out for with regards to something that would require them to warrant more urgent attention or a call back or to seek care in the emerg department with regards to the red flags.

1:26:05
So, when there's a change in their condition, you're partnering with the patient as well to enlist them in that scenario with regards to preventing those delays in diagnosis versus, "Well, I'll just wait to hear from my doc in four to six months", and meanwhile, they're getting a lot worse.

1:26:20
Other things that are important that we may want to consider is: is there an opportunity to actually manage care of our patients with the family physicians and consultants co-jointly until the definitive test can occur? And certainly, we've seen that innovation creativity already during the pandemic with specialists and family docs working together to try to mitigate some of those risks for our patients, because we're worried about them. We want them to be taken care of.

1:26:48
We certainly have seen people innovating with their colleagues, where they actually have now introduced virtual care or learned a different triage system to actually decrease their wait list in new and innovative ways, or share resources with other neighbouring hospitals or colleagues to, again, prune that list down.

1:27:07
So these are not, you know, solutions that perhaps are the magic pill or a magic wand, but the importance of those communications along the way as we are in this situation and done in a respectful and caring way is really important — and also to document what you communicate is also really crucial too, because those will certainly be taken into consideration when there are delays in the diagnosis or care, right, Donna?

1:27:36
Donna M. MacKenzie: Correct. Absolutely, Shirley, and — and Tino, if you can just give me a second, I just want to put in a plug for ensuring that your assistance, your office managers, your non-health care professionals who are a part of your health care team are also doing that communicating and that documenting of it.

1:27:57
You know, I see too many times in our files where the patient says, "But I contacted" — and this is in pre-COVID times — "I contacted the doctor's office six times", and we go to the chart and there's nothing in there. Did they contact the doctor's office three times or six times? I've got nothing. So particularly when you've got pa — patients who are anxious to know what's going to go on, you're not, as the physician, going to be able to have all those calls. You've got to delegate those calls.

1:28:30
But if you're having someone else speak to your patients, please have that someone else document so that they are documenting what that conversation was; and please communicate with that individual to say, "Okay, I imagine you're getting a lot of calls.

Give me a sense of what information is coming through, and are there any patients that you're particularly current — concerned about", you know? Give them guidance to do their job and then give them an opportunity to tell you about how they're doing their job. And that, to me, helps close the full loop of the team. Thanks.

1:29:10
Dr. Tino D. Piscione: Great. Thanks very much, Donna, for — for highlighting that particular aspect of — of practice.

1:29:18
Janet, I believe we have a question — a French language — in French?

1:29:23
Dr. Janet Nuth: Oui, Tino —

(voice of translator)

1:29:24
Yes, Tino, we do have a question in French for Dr. Dion. You — you've received a copy of an exam report and there was a serious diagnostic in the report, but you didn't ask for the exam to be done. What is your duty with respect to the patient?

1:29:48
Dr. Louise Dion: Thank you, Janet. I think I heard the collective sigh throughout all of Canada because it happens to a lot of doctors. It's frustrating because it requires time and it requires energy to ensure that action is taken on the test for the patient.

1:30:09
There are different scenarios that can take place. So for example, there's a scenario where you have been CC'd by the requesting doctor, but you weren't aware that the test was asked for. The patient might be one of yours or a patient that is not part of your practice.

1:30:27
The last scenario, which is the most disturbing one — and this is one that's particularly disturbing — is that you receive a copy of a test that you didn't ask for. So, you didn't ask for the test, but it's a really abnormal test, and nobody else is copied on the test results.

1:30:44
If we look at the first two scenarios, or in fact, if we look at all of the scenarios, the courts and the colleges have said that the requesting doctor who is asking for a test is responsible for doing a follow-up on the test or to ensure that somebody else will do the follow-up in his or her place. That means that it has been delegated to somebody else and that this other person that has been delegated has been — has accepted.

1:31:19
Does that mean that because you didn't request a test, that you don't have any duty with respect to the patient? Can you simply take the test and put it in the garbage pail? The answer is probably no. The — you're not necessarily — they're not necessarily set aside in terms of responsibility. (sic) There's probably collective responsibility.

1:31:43
So, in the first two scenarios where you've been CC'd and the doctor has received a copy of the test, the important thing is to clarify if it's not clear who is the doctor responsible for the patient. If it's clear, great, but if it's not clear, you might want to contact the requesting doctor to make sure that he or she has seen the test and who is responsible for following up on the test.

1:32:11
Or, if this is a patient from your practice, then call the patient to see: have you seen the doctor that has requested this test? Is there something that's going to happen now? Ensure yourselves that that patient will have a follow-up.

1:32:26
As for the last scenario, you've received a test that you have not requested. Your duty, your responsibility has not been set aside because this is not somebody that you know. Time — sometimes, there's a new doctor who comes in a neighbourhood and has the same name as you, and you might realize that that test has — has always been sent to you. You might want to be able — you want to — rather, you might want to call this person, this doctor, to make sure that they've seen the test and that a follow-up will be done.

1:32:56
If it's impossible for you to know who requested the test, then you might want to contact the patient. Oftentimes, there's a phone number on the chart — to check with the patient: who is your doctor? Had they seen — have you seen your doctor? What is the follow-up? And then, you should contact the doctor.

1:33:14
The important thing that happens when you receive something that is not addressed to you is to inform the laboratory that have sent you this — the result in error, to ask the lab once again to make sure that they advise the treating doctor — physician — and to make sure that — that — this doesn't happen too often.

(end of translation)

1:33:42
Dr. Tino D. Piscione: Merci, Louise.

(voice of translator)

1:33:45
Thank you, Louise.

(end of translation)

1:33:47
We've got time maybe for one or two more questions. We're getting — a lot of members are asking about virtual care, and so maybe what I'll do is I'll just ask you.

1:34:00
For many — for many physicians who are providing mostly virtual care or perhaps even almost exclusively virtual care at this moment… Any advice or tips to them on how they can both help their patients and also reduce their own medical legal risk while their patients are waiting for definitive diagnostic procedures? And they're delivering all their care virtually.

1:34:28
Dr. Shirley Lee: Yeah, so as I alluded to earlier about the CMA virtual playbook, it's an excellent resource. If you haven't had a chance to look at it, I would highly recommend our members to take a look at that book, because it has excellent national guidelines that we are using in Canada and sort of sets the stage for reasonableness in standard of care.

1:34:47
In this particular situation, Tino, that you're talking about, again, there is the importance that we need to document those conversations with patients, even if they are virtual, with regards to any issues regarding resource scarcity or monitoring of the condition. And the good news is that these days we do have some means to do self-monitoring of patients at home, whether it's their blood pressures or glucose, those kinds of things.

1:35:13
I had mentioned earlier about the importance of red flag signs and symptoms, and I — and I think, again, this is another opportunity not only to mention them as physicians, but you need to actually understand from the patient's perspective, to verify their understanding. What's your understanding of when you would need to seek care? Actually ask them that — don't just tell them, because they'll nod and say "yes" because they're just happy to talk to you. But do they actually know when they actually need to come back, when they are still waiting for those definitive diagnostic procedures, or, for example, they have chest pain and you're worried that it's a cardiac cause.

1:35:43
A more urgent assessment needed by a physician or that they need to go the hospital would be important to outline to your patient, and to set those expectations with regards to time frames, okay, that are appropriate for getting the testing done.

1:36:00
Act in the patient's best interests. Patients can sense when you're not sincere. It's really important that we as health care practitioners maintain that with regards to ensuring that we share that information in a respectful manner. Some patients will not be pleased sometimes when they hear about the potential delays or things like that, and they may seek care elsewhere. It's possible. But make sure that you do actually document those conversations you have with the patient, because these are sometimes difficult conversations to have with patients, but if they know that you're acting in their best interests or advocating for them or calling the specialist directly, that certainly goes a long way to their understanding of — that you're doing the best that you can for them.

1:36:41
Dr. Tino D. Piscione: Thank you. Thanks, Shirley, for — for that response.

1:36:43
Unfortunately, we're going to have to close the Q and A section of today's session since we're nearing the end of our time together. A very special thank you to our panel for sharing their insights on this important topic.

1:36:54
We also ask you to remember to complete the post-event serve way — survey. It should be in your inbox of your email. If it's not there, check the spam folder. Unfortunately, sometimes it ends up there. We truly appreciate your feedback. I mean, this year's session was largely guided by feedback that we got from last year's session. So don't hesitate to share your thoughts, good or not so good. I mean, we welcome your input. It's only with your feedback that we can design education sessions to meet your learning needs.

1:37:25
So we'll wrap up by reminding you of our three key message. (sic) Remember — information gaps. Ask yourself: am I missing something, and where do I need to go to get that information?

1:37:38
Dr. Janet Nuth: And then, the second key message, of course, is no one expects you to be perfect. The expectation is to exercise reasonable skill and judgment when it comes to your diagnosis, and let your documentation reflect your intellectual footprint in the medical record.

1:37:54
Dr. Tino D. Piscione: And that third key message was leverage team communication to raise team situational mare — awareness and make sure that everyone is on the same page.

1:38:05
Dr. Janet Nuth: And Tino, we want everyone listening today to now take a

little piece of paper or a sticky note. Write one thing that you're going to do differently to reduce your risk of diagnostic errors and keep patients safer. We're going to be asking you this on — on our evaluation, so write down one thing that you commit to doing a bit differently to improve patient safety.

1:38:33
Dr. Tino D. Piscione: Great, and don't forget to check out the CMPA website, which has many resources on the topic of diagnostic error, but also on other topics relating to promoting safe care and reducing medical legal risk. While you're there, you can check out our new good practices web page, which allows you to search on specific topics, and there's updated e-learning activities that you can use — that you can complete to earn CME credits, as well as links to CMPA-produced podcasts and micro learning activities on a range of medical legal topics.

1:39:09
We also have the COVID website, which also has a lot of important information relating to the pandemic; and we also offer workshops for CMPA members that are specifically dedicated to reducing diagnostic error, and the information regarding scheduling, registration, and accreditation is available on the website.

1:39:36
And of course, most of all, we sincerely appreciate you taking time out of your schedule today to attend our event. We truly appreciate the challenges and the personal sacrifices that many of you have faced this past year and a half. We're grateful to you for your dedication to your patients. We thank you for your participation today, and on behalf of Dr. Janet Nuth and our esteemed panelists, we all hope that you will enjoy a safe summer.

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